Accident & Injury Report Form

Attending Physician's Statement

Please arrange for this form to be completed by **the patient's usual doctor**.

You can return it to us via the contact details listed below.

Important:
We respectfully request that this form is completed with as much detail as possible in order to assist our processing and avoid the necessity of additional enquiries.

Claimant Name: **Claim Reference Number:**

Policy Number Sex ☐ Male ☐ Female Age

The Insured is responsible for completion of this form without expense to the company

Patient's name

Address

Please give a complete diagnosis of this condition

History

1. When did the patient first receive medical treatment?
2. a) Was there a previous history of this or a similar condition? ☐ Yes ☐ No
   b) If Yes, please state condition and advise when previous treatment was given
3. a) How long have you known the patient?
   b) Are you the regular general practitioner? ☐ Yes ☐ No
   If not, please advise who is

If Injury

1. When did patient suffer the injury?
2. What were the circumstances surrounding the injury?

If Sickness

1. When was the sickness first contracted?
2. When did symptoms become evident?

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Degree Of Disability

1. Patient's Occupation?
2. When was patient obliged to cease work?
3. If patient is still disabled, when approximately will the patient be able to resume
   a) Some Duties?
   b) Full Duties?

OR

4. If patient has recovered, when was patient able to resume
   a) Some Duties?
   b) Full Duties?

Treatment Of Present Condition

1. When were you consulted? (a) Initially (b) Most Recently
2. How often has patient consulted you?
3. Was patient confined to hospital? ☐ Yes ☐ No
   If Yes, please advise
   1. Name and address of hospital
   2. Period of confinement From to
4. Was confinement in a convalescent home necessary after hospitalisation? ☐ Yes ☐ No
   If Yes, give details
5. What are the current subjective symptoms?
6. Please give results of any objective findings
   1. X-Rays
   2. Other Tests - Please advise tests done and findings
      1
      2
7. What surgical procedures have been performed?
      1
      2
8. What surgical procedures are contemplated?
      1
      2
9. What other treatment has patient undergone?
10. What other treatment is required?

Are there any underlying conditions affecting recovery from the current condition? ☐ Yes ☐ No

If Yes, please advise nature of underlying conditions and how they affect disability and recovery

Has the patient any other physical or mental impairment? ☐ Yes ☐ No

If Yes, please describe

Please advise names and addresses of other treating physicians

If you have terminated treatment, please advise date

What was the current prognosis?

Are there any further remarks which may assist in assessing this condition?

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- assessors, third party administrators, emergency providers, medical providers or travel carriers, or any third parties or insurer from whom AIG seeks recovery related to the claim; and
- government, law enforcement, dispute resolution, statutory or regulatory bodies, or as required by law.

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Our Privacy Policy is available at www.aig.com.au or by contacting us on 1300 030 886 and contains information about how you may access and correct your personal information, how to complain about a breach of the applicable privacy principles and how AIG will deal with such a complaint.

Signed

Date / /

PLEASE KEEP A PHOTOCOPY OF ALL DOCUMENTATION YOU SEND TO US FOR YOUR OWN RECORD

AIG Bring on tomorrow

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